

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN2603 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 09/29/2010 |
| NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABIL | | | STREET ADDRESS, CITY, STATE, ZIP CODE 32 MEMORIAL DRIVE WINCHESTER, TN 37398 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| N 000 | Initial Comments Complaint investigation #'s 24173, 24685, 24692, 25902, 25910, 25921, and 25923, were completed at Willows at Winchester Care & Rehabilitation on September 27 - 29, 2010. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | | |

Division of Health Care Facilities

[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE

10/12/10

STATE FORM

6899

6R7P11

If continuation sheet 1 of 1

OCT 13 2010